



“What if I’m not trans enough? What if I’m not man enough?”: Transgender young adults’ experiences of gender-affirming healthcare readiness assessments in Aotearoa New Zealand

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ABSTRACT

Background: A growing body of transgender health research reports that transgender people often feel pressure to conform to a dominant narrative during gender-affirming readiness assessments. In New Zealand, however, no study to date has specifically examined transgender people’s experiences of readiness assessments for gender-affirming healthcare.

Aims: This study aimed to explore the experiences of transgender young adults (aged 16–30) during gender-affirming readiness assessments in New Zealand. We also sought participants’ views on improving transgender healthcare provision.

Methods: Thirteen transgender young adults took part in individual interviews or focus groups. Participants were asked to describe how they felt about the questions asked during readiness assessments and how the readiness assessment process could be improved. We used thematic analysis to identify patterns of meaning across the dataset.

Results: We identified two themes. Firstly, *proving gender* explores participants’ views of readiness assessments as designed to establish whether they were “trans enough” or “truly” transgender, and why readiness assessments are conducted in this manner. Secondly, *the trans narrative* describes the pressure participants felt to adhere to a dominant transgender narrative in order to gain access to the healthcare they needed.

Discussion: Our findings call attention to the importance of a trans-affirmative approach and the need to clarify the purpose of gender-affirming healthcare readiness assessments in New Zealand.

KEYWORDS

Gender-affirming care; New Zealand; qualitative research; readiness assessments; transgender

Introduction

A well-established body of research provides empirical support for the efficacy of gender-affirming healthcare, demonstrating that access to medical transition services decreases transgender (trans) people’s gender dysphoria, improves psychological symptoms, and increases quality of life (Dhejne et al., 2011; Murad et al., 2010; White Hughto & Reisner, 2016). Standards of care (such as the widely used World Professional Association for Transgender Health [WPATH] standards; Coleman et al., 2012) generally require trans people to undergo a readiness assessment with a mental health professional before accessing puberty blockers, hormones, and/or surgery. In this paper, we present the first study of trans

young adults’ experiences of readiness assessments for gender-affirming healthcare in New Zealand.¹

Trans experiences of readiness assessments

International best practice guidelines for providing gender-affirming healthcare reject a pathologizing model of care (which focuses on ascertaining whether clients are “truly trans”; see Riggs et al., 2019; Vipond, 2015 for discussion) in favor of a model of care that focuses on the presence of gender dysphoria, and on patients being informed of the risks and benefits to treatment and capable of making their own health choices (Schulz, 2018). Despite this, previous international research reports many trans people

feel pressure to conform to a dominant narrative during readiness assessments for fear their identity and experience may not be viewed as legitimate enough to access gender-affirming healthcare (Ellis et al., 2015; Frohard-Dourlent et al., 2020; Lykens, et al., 2018; McNeil et al., 2012). This dominant narrative includes identifying as part of the gender binary, feeling “trapped in the wrong body” from a young age, experiencing significant distress, and wanting a “full” medical transition – that is, hormone treatment as well as genital surgery (Davy, 2015; Lewis et al., 2017). Many trans people express concern that they will not be referred for gender-affirming healthcare if they describe experiences that deviate from this narrative, such as feeling satisfied with one’s genitals, having a nonbinary gender identity, or having identified as trans for a relatively short time (Davy, 2015; Lykens et al., 2018; Rowe, 2014).

The involvement of mental health professionals in the process of accessing gender-affirming healthcare complicates the experience of support seeking for many trans people (Riggs et al., 2019). Mental health professionals are often viewed as gatekeepers by their trans clients (Lev, 2004; Sperber et al., 2008; Taylor, 2013), and trans people often describe this gatekeeping element as having a negative effect on their relationship with their health providers (Rachlin, 2002; Taylor, 2013). Indeed, clients may have to decide whether they will be open about their distress or emotional state, in the knowledge that this may impact on their access to gender-affirming healthcare.

Although “clinically significant distress” is required in order to meet the diagnosis of gender dysphoria (American Psychiatric Association, 2013, p. 453), trans people could be prevented from accessing gender affirming healthcare if they are *too* distressed, as a mental health professional may not consider their functioning as stable enough to start treatment (Coleman et al., 2012). There is ongoing debate as to whether health professionals providing gender-affirming care should adopt an informed consent approach (which could mean that readiness assessments cease to exist altogether), rather than continuing to use the WPATH model of care. Advocates of

informed consent argue that there is a need to move beyond diagnosis in order to “counter the negativity attached to trans embodiment in medical discourse” (Davy, 2015, p. 1166).

Gender-affirming healthcare in Aotearoa New Zealand

In Aotearoa, trans people can access gender-affirming healthcare through the public health system (McDonald & Byrne, 2015). Funding for genital surgery is provided at a national level (Ministry of Health, 2018a), and other gender-affirming healthcare services (e.g., hormone therapy, puberty blockers, mastectomy, and hysterectomy) are provided by patients’ local District Health Board (DHB; Ministry of Health, 2018a). There is remarkable inconsistency between DHBs regarding which services are available and funded (Fraser et al., 2018), and trans New Zealanders report widespread knowledge gaps among health practitioners regarding the provision of trans healthcare (Wi-Hongi et al., 2017). An assessment by a mental health professional is routinely required to access gender-affirming healthcare, however there is ongoing confusion about what such assessments should contain, or who is qualified to carry them out (Wi-Hongi et al., 2017).

The few published studies of trans peoples’ healthcare experiences in New Zealand describe a similar experience to those reported overseas. The New Zealand Human Rights Commission Report of the Inquiry into Discrimination Experienced by Transgender People (2008) described the provision of publicly funded gender-affirming healthcare as “patchy and inconsistent” (p. 50) and reported that some trans New Zealanders had been refused publicly funded readiness assessments. Trans participants in other New Zealand studies described a need to “fit a textbook description” (p. 171) of what it meant to be transgender in order to access gender-affirming healthcare (Pitts et al., 2009), and reported taking a cautious approach to discussing mental health issues for fear this would prohibit them from accessing hormone therapy (Ker et al., 2020). The largest study to date of the health and wellbeing of trans and nonbinary people in Aotearoa

($n=1178$) reported high levels of unmet needs for gender-affirming healthcare, unclear treatment pathways, and lengthy waiting times to access care (Veale et al., 2019).

The current study

Previous research reports that trans people, both in Aotearoa and internationally, feel significant pressure to conform to a dominant trans narrative in order to access gender-affirming care. However, no published New Zealand-based study has specifically examined trans peoples' experiences of readiness assessments for gender-affirming healthcare. As such, there is an ongoing lack of clarity about the nature of questions asked during readiness assessments in Aotearoa, whether New Zealand health professionals adhere to best practice guidelines, and how trans people in New Zealand suggest gender-affirming healthcare readiness assessments can be improved.

We use a qualitative approach to fill this gap in the literature. Because the experiences of LGBT people vary considerably by age (Russell & Bohan, 2005), we thought it important to narrow our age range to allow for meaningful analysis. We focused on young adults in light of previous findings that trans young adults are at increased risk for many negative health outcomes (Clark et al., 2018) and face significant challenges when accessing healthcare (including difficulties accessing care and having less power than older health consumers in interactions with healthcare professionals; Lykens et al., 2018). We ask: *What are trans young adults' experiences of gender-affirming healthcare readiness assessments in Aotearoa New Zealand?*

Method

Parent study

Data for this study were collected as part of a wider interview study of rainbow peoples' experiences of accessing mental health support in Aotearoa New Zealand ($N=34$). Participants were invited to take part if they (1) identified as queer, takatāpui,² nonbinary, trans, LGBTQIA+, MVPFAFF,³ or questioning, (2) were aged 16-30,

and (3) had accessed, or considered accessing, mental health support in New Zealand. Interviews were conducted May-September 2017 and approval for the study was granted by the Victoria University of Wellington Human Ethics Committee. Participants were given either a supermarket, petrol, or cinema voucher to thank them for their time. Our primary recruitment strategies were social media posts by rainbow community partners, snowball sampling, and targeted emails to mental health and rainbow organizations (see Fraser, 2020 for the full study protocol).

The parent study was conducted in partnership with rainbow and transgender community organizations. Community organizations provided guidance and feedback at each stage of the research process (including decisions about the scope of the study, proposed interview questions, and draft recruitment materials), and worked with our research team to ensure we created a respectful and validating space for their community members to share their experiences. A community-based approach is best practice for any trans health research project (Adams et al., 2017), as it ensures participants' safety, improves research quality, and helps researchers to avoid the mistakes of their predecessors (for discussion, see Meezan & Martin, 2003). We felt this approach was particularly important for us, as our research team has no lived experience as trans. Our research team included: a straight cisgender woman (PhD and Clinical Psychology student), a queer woman (Senior Lecturer of Media Studies), a straight cisgender man (Professor of Psychology), a bisexual cisgender woman (Counseling student), and a bisexual cisgender man (Psychology graduate).

Participants

Participants for this study were transgender participants who described their experiences of accessing (or attempting to access) gender-affirming healthcare in the course of their interview ($n=13$). Of these participants, 10 accessed gender-affirming care in Aotearoa, two accessed care overseas, and one accessed care both in Aotearoa and overseas. Discussions of gender-affirming readiness

assessments in New Zealand all related to hormone therapy, while readiness assessments overseas related to hormone therapy and top surgery. Where we discuss experiences outside of New Zealand, we specify this in the analysis.

Participants were aged 17-26 ($M=22.2$). At the time of data collection, participants described their gender as follows: five as trans men; three as trans women; one as trans femme; one as a nonbinary trans woman; one as agender; one as transfuid; and one as genderqueer, transfeminine. Participants described their sexual orientation as follows: five as queer; three as gay; one as bisexual; two as pansexual; one as pansexual, polyamorous; one as asexual, hyperromantic. Twelve participants were living in urban centers, and one lived in a rural area. With regard to ethnicity, nine participants were Pākehā (New Zealand European), three were Pākehā and Māori (indigenous New Zealanders), and one was European American. All participants but one were born in New Zealand. Participants were given the option of taking part in an individual semi-structured interview or taking part in a focus group; eight chose to take part in an individual interview, and five chose to take part in focus groups. Participants were given the option of choosing their own pseudonym, and those who declined had a pseudonym allocated following transcription.

Data collection

Interviews were conducted in three major cities: Auckland ($n=4$), Wellington ($n=6$), and Christchurch ($n=3$). They ranged between 54 and 104 minutes in length ($M=83.4$) and were conducted and transcribed by the first author. Participants who shared they had accessed, or were in the process of accessing, gender-affirming healthcare and consented to discussing this further were asked how they felt about the readiness assessment process, if they found this helpful, if they understood why particular questions were asked, and if they agreed with the questions asked and rationale for doing so. If participants had seen a mental health professional for their readiness assessment, they were asked if the reason for seeing the mental health professional was clear to them. Participants were also asked to

reflect on how the readiness assessment process could be improved.

Data analysis

Data were analyzed using thematic analysis, a method for identifying, analyzing, and reporting patterns of meaning (themes) within a data corpus (Braun & Clarke, 2006, 2013). We took a critical realist approach to our analysis, which “assumes an ultimate reality, but claims that the way reality is experienced and interpreted is shaped by culture, language and political interests” (Braun & Clarke, 2013, p. 329). Once all participants were given the opportunity to review and edit their transcript, the first author read and re-read all transcripts and took notes about aspects of the data that seemed particularly important or interesting. Following this the first author coded all transcripts, and two research assistants coded a subset of transcripts ($n=8$). The first author then collated codes for potential themes into “theme piles”, read all extracts for potential themes, and considered whether the data cohered together meaningfully. Finally, all authors and research assistants met to discuss and revise the candidate themes.

Results

We identified two themes related to experiences of gender-affirming healthcare readiness assessments: Firstly, *proving gender* discusses participants’ experiences of the system as designed to establish whether they were “trans enough” or “truly” trans. This theme also outlines participants’ reflections as to why readiness assessments are conducted in this manner. Secondly, *the trans narrative* encompasses participants’ talk about feeling pressure to present their gender in a particular way in order to gain access to the healthcare they needed.

Proving gender

Participants commonly reported that their mental health professionals seemed interested in establishing whether they were “really trans” or “trans enough” during their assessment for gender-affirming care:

Henry: The psychologist should take you seriously instead of going out of their way to sort of prove you're trans (...) They're always second guessing you and trying to really really really make sure that you're really trans and really ready to commit when it's not you haven't said that 200 times already.

Here, Henry notes that describing himself as trans was not sufficient for his health professionals to acknowledge his trans identity. Instead, his psychologist asked a series of questions Henry saw as designed to "prove" his gender identity. Several other participants described similarly lengthy conversations in which their health professionals questioned them about how they knew they were trans, or if they were sure they were trans. Theo stated, "they seemed to have endless questions about gender," and described the assessment process as "exhausting." "I hated the question 'are you sure?' because why am I here then, honestly, I wouldn't be seeking this if I wasn't sure".

Hugo stated that he was so consumed with worry leading up to his readiness assessment that he noted his thoughts down on his phone for his mental health professional to read:

Hugo: I went to him and I was like "what if I'm not trans enough? What if you're not gonna give me what I want? What if I have to go find someone else cause I've already waited for three months to see you and what if you're not gonna let me do the thing I want to do? What if I'm not man enough?" blaarrgghhh! And then I wrote on my phone cause I was too like, scared to say it, I was just heartbroken so I just like gave him my phone and I was like "just read this thing that I wrote to you!"

Hugo's account emphasizes how distressing readiness assessments for gender-affirming healthcare can be for trans people. Hugo accessed gender-affirming healthcare outside of New Zealand, but his perception of the readiness assessment as a test to be passed (rather than as an opportunity to access support and make plans for the future) closely reflected the talk of other participants. Hugo's use of "heartbroken" illustrates that gatekeeping by mental health professionals not only has the potential to deny clients access to the healthcare they need, but to exacerbate their existing distress.

Although some participants noted that questions around gender dysphoria were asked in a respectful and sensitive manner, others reported that their mental health professional's questioning had felt insensitive:

Alexis: I was often asked by different people the same questions, over and over and over again, and this one doctor, apparently big advocate, no tact, who would go "so do you want a vagina? Do you want to get rid of your penis and have a vagina instead?" and by just saying that you can get the grossness, right? So I got asked a lot of those kind of questions, and I felt like I had to answer them.

Alexis recounted the doctor's words in an indelicate, abrupt fashion, checking she had communicated the unpleasant nature of the interaction ("you can get the grossness, right?"). Alexis' impression of the doctor suggested that their questions were not only phrased poorly but were delivered in a tone of voice that indicated a lack of awareness about the sensitive nature of their questions. Alexis' experience highlights the importance of subtle signals of safety, including tone of voice and body language. Also of note in the above extract is Alexis' comment that she felt like she *had to* answer the questions. Other participants described feeling the same way about answering questions they were uncomfortable with, highlighting the difficulties of obtaining free consent within a system where health professionals hold the power to make decisions that have significant impact on their clients' lives and wellbeing.

Many of the assessment questions that participants described seemed to reflect attempts to establish *when* participants began to experience gender dysphoria, or describe themselves as trans. Henry, for example, noted that he felt an expectation on the part of his mental health providers to pinpoint the time at which he realized he was trans:

Henry: It's a really hard question to answer, how long have you known. I usually just say that I've known since I was about 16, but it's not something that you can just pinpoint (...) it's not something like, you can just put your finger on and be like - March 2007 is when I knew at 12.51 pm (laughs) it's not like that.

Henry explained that now, when he looks back on his life as a younger person, he recognizes

many of his feelings as internalized gender dysphoria, but at the time had not yet understood his trans identity. Here, he highlights that this does not make his gender identity invalid; that many trans people experience gender dysphoria for years before labeling it as such, so attempts on the part of mental health professionals to establish how long someone has been identifying as trans are largely irrelevant in the process of providing gender-affirming healthcare.

Although all participants had initially sought gender-affirming healthcare as adolescents or adults, several participants described questions they were asked about the clothes they wore and the toys they played with during childhood – “I was asked stuff like, so did you do a lot of dress up when you were a kid? Did you cross dress when you were a child, and did you like to play with dolls?” (Alexis). Henry also noted that he was asked several questions about his childhood, summarizing this line of questioning in his assessment with the joke, “you know, did you know from age two onwards that you weren’t cis?”

As well as a focus on childhood experiences, participants reported a focus on their gender expression during assessments for gender-affirming healthcare:

Felix: In part of my psych assessment to begin testosterone my psychologist had to specify how I dressed (...) and when I started dressing as the other gender.

Henry: They mentioned how I dress, what color my hair was, the fact I have piercings, my body language, how I sit, how I talk, how I speak (...) It’s like, why do you need to know what color my hair is, or the fact my nose has two piercings, like wow, if I only had one ring in my nose, would I still be trans, you know?

Felix and Henry both noted that mental health professionals seemed to view their gender expression as evidence of their gender identity. Felix and Henry went on to reflect that if gender is socially constructed (as they both understood it) then the only way to understand another person’s gender is to ask how they describe themselves; it is impossible to assume gender based on someone’s outward appearance. For many participants, this tendency on the part of professionals to connect gender identity with gender expression

informed the way they expressed and described their gender within assessments.

The majority of participants reported that, although their assessments for gender-affirming healthcare were typically very lengthy and/or had involved persistent and uncomfortable questions about their gender, they believed that their mental health professionals wanted them to have access to the care they needed. Some participants posited that the questions asked during their readiness assessments were determined by the requirements of the “system”. Henry, for example, noted that his psychologist had apologized for the invasiveness of the questions she asked; he stated, “the professionals don’t necessarily agree with the questions they’re asking but they know they have to ask them, cause that’s how the system is.” Other participants made similar comments, with Martin noting that the purpose of a readiness assessment was “to tick their boxes” and Hugo mentioning it was “needed for the paperwork”.

As well as speculating that institutional or “system” requirements account for the nature of readiness assessments for gender-affirming healthcare, some participants posited that mental health professionals attempt to ascertain that clients are “really trans” (that is, they will always understand their gender in this way and continue to access to gender-affirming healthcare) out of concern that their client would later realize they were *not* trans and would subsequently regret accessing gender-affirming care (this is often referred to as “desistance” or “detransition”; Serano, 2016):

Lily: The worry is that we need to know for sure because you might mess someone’s life up if you do it wrong.

Henry: It’s because they’re afraid of people making irreversible changes and not fully understanding the effects that, like, for example testosterone will have on the body and the fact that, you know, even if you stop taking it, you know, not all the effects are going to be reversible and there’s kind of no going back.

Lily and Henry anticipate a fear on the part of health professionals that, if someone were to access gender-affirming care and subsequently experience a change in gender identity, this would

have a significant negative impact on their life due to the irreversible bodily changes that can come with gender-affirming care. As Henry points out, some effects of testosterone (including clitoral growth, facial hair growth, voice changes and male-pattern baldness) are not reversible after hormone therapy is stopped (although the degree to which changes are reversible depends on how long someone has been on hormone therapy; Deutsch, 2019). Estrogen hormone therapy also has irreversible effects, including some breast growth, and possibly reduced or absent fertility (Deutsch, 2019), and gender-affirming surgeries are typically irreversible (Bizic et al., 2018).

Some participants challenged the idea that accessing gender-affirming healthcare and later ceasing treatment is always harmful or distressing:

Willow: It's more of a fear among professionals than among queer people, I think, it's something that they like to push on you, like the boogie man, like what if you're not what you think? And honestly, we're all bundles of muscle and fat walking around in meat suits, so it doesn't really matter in the large scale of things, if it's something that you need to explore, then you need to explore it, like, maybe you do detransition, maybe you do end up with slightly weirdly shaped body (...) but yeah that shouldn't be held over your head as like a threat.

Here, Willow suggests that the negative impacts of detransitioning may be exaggerated by health professionals and that for some people, accessing gender-affirming healthcare might be necessary step in order to understand their gender. Nala expressed a similar sentiment, noting during a discussion of detransitioning that "maybe even they needed to like, go through that process".

Star, who previously identified as a trans man (accessing gender-affirming healthcare overseas), also drew on the idea of gender as a journey (see Temple Newhook et al., 2018) when discussing detransition:

Star: There's just a lot of fear that if somebody transitions and then changes their mind what if the doctors are held liable for not like, ruling out all factors? (...) I don't really resent them or anything, cause first of all I don't regret any of the stuff that happened, cause it was what worked for me then, and I'm not

having any problems relating to it now, honestly, I'm fine with it. (...) I don't regret getting top surgery and I have people ask me sometimes like "but now that you're kind of being a woman again, like isn't it horrible not having this huge womanly part of you?" First of all, that's not, that's not really a womanly part of me, it's just a part of me, and second of all I can wear so many more shirts now! (laughs).

Here, Star reflects that to move through different ways of identifying or understanding one's gender does not reflect a failure or mistake, either on the part of health professionals who provided gender-affirming care, or the person who has received the care. She also shared that her health professionals acted in accordance with best practice, as they had given her the care she needed when she needed it. In conversations around treatment regret, other participants considered the potential outcomes of gatekeeping versus making care more accessible. Alexis noted that health professionals tend to lean toward the former, stating that "there is this attitude that it is better to deny thousands of trans people, than to let one cis person transition and regret it."

The trans narrative

Almost all participants who had accessed gender-affirming healthcare shared that, because assessment questions seemed focused on establishing that they were "truly trans" or "trans enough", they felt there was a particular story they had to tell about their gender in order to access care:

Henry: I guess what [the questions do] is put a lot of pressure on trans people for feeling like they have to fit a sort of perfect mold, and that's why I ended up, not really lying on impulse, because later when I thought about it I was like hey no I was right, but just getting scared that if I didn't appear completely mentally stable or completely 3000% sure of my gender, that they would just not take me seriously because of the sort of style and approach of the questions.

Henry's use of the word "scared" emphasizes the high stakes involved in readiness assessments for gender-affirming care. Henry describes fears that his professional would believe he was unsure of his gender, or not well enough to make decisions

regarding his gender and deny him hormone therapy as a result.

Several other participants also shared that they felt pressured to fit this mold or conform to a typical narrative in order to access the care they needed:

Felix: If you don't want to have the full medical transition, then you're automatically disregarded, you're not valid, it was brought up for me a lot as well, I was constantly being asked, "how far do you want to go with the surgery?"

Felix notes that, for many health professionals, wanting genital surgery is a necessary part of identifying as trans. Although participants' perceptions of the trans narrative varied slightly, all agreed that this involved having a binary gender identity, knowing they were trans since a very young age, and wanting a "full" medical transition (that is, hormones, genital surgery, and top surgery if applicable).

Several participants explained that they either had put forward the trans narrative in order to access care, or would in future, even if that narrative did not fit with their story. Bats (who is nonbinary), for example, shared that:

Bats: I want top surgery, but on my letter to apply for top surgery I'm going to be a man. I'm a man, I want my boobs gone because boobs aren't for men, and I'm gonna be the manliest man, and I'm just gonna say that, so I can get my surgery.

Here, Bats reflects that New Zealand's health-care system typically draws on a binary understanding of gender to inform decisions around gender-affirming surgeries. For Bats, presenting their nonbinary identity to healthcare professionals may be a risk; instead, it is preferable to claim a male gender identity and have a higher chance of accessing the care they need.

Other participants shared experiences along the same lines and noted that embodying the dominant trans narrative was not only about how they described their gender identity, or gender journey, but about how they expressed their gender in session.

Willow: You've got to present the facade of the 50s housewife if you want to get anywhere. With all the uncomfortableness of that, the connotations of that (...) you have to basically play on a bunch of stereotypes. One of my friends was being the older cynical trans, and she was like yeah just, if you're going to go to another one of those appointments, the first thing you do is go full high femme, you know, long skirts and high heels and way too much lipstick, et cetera.

Willow's experience of hearing advice from older trans community members was common among participants. Many reported that they had been told by those who had sought gender-affirming care in the past that it was important to dress in a hyperfeminine or hyper-masculine manner to their appointments, even if that was not how they usually expressed their gender, in order to avoid any doubt on the part of professionals that they were "truly" trans.

Participants shared that the pressure to conform to a dominant narrative felt unjust, as access to gender-affirming healthcare should not be restricted to one type of trans person. They argued that, because the trans community is so diverse, care should be available to all who need it, regardless of how they experience or express their gender. Lily shared that pressure to tell the trans narrative not only made her feel uncomfortable, as it was inconsistent with her experience of gender, but also limited what she was able to discuss with health professionals in later sessions:

Lily: I've had this experience where you kind of set yourself up as the relatively typical trans person, we tell the typical narrative of playing with girls' toys when you're little and trying on mum's makeup and all that kind of stuff (...) but having said all of that, it means that I now can't come back later and say "I want to retain the use of my penis" because it's like oh but you're the typical trans woman who's always felt wrong in your body and wants a different body and all the stuff, and it's like, well actually no I'm quite okay with my body.

Lily went on to explain that she was dissatisfied with the effect that hormones had on her sex drive but felt unable to discuss a change in prescription with her doctor, as "trans women are supposed to not like their genitals" so should not want to use them for sex. Lily noted that

trans women are “supposed to kind of have one or the other” – that is, trans women are expected to sacrifice either their sex life or their hormone therapy.

Discussion

This study used thematic analysis to explore trans young adults’ experiences of gender-affirming healthcare readiness assessments in Aotearoa New Zealand. The majority of participants saw a mental health professional for an assessment in order to access gender-affirming healthcare, and typically understood these assessments as designed to prove they were “truly trans” or “trans enough”. Participants tended to attribute this need to prove gender to the requirements of the system, or to a fear on the part of their health professionals that they would later regret their decision to access gender-affirming care. As a result of professionals’ focus on participants’ gender identity and expression, many reported that they felt pressure to present their gender in a way that fits a dominant trans narrative, where they had known they were trans from a young age, expressed their gender as hyperfeminine or hypermasculine, and wanted all available medical transition options.

The questions participants were asked about their childhood experiences of gender, discomfort with their genitals, and adherence to the gender binary reflect the medical model of trans identity (and the medicalization of trans bodies), where the purpose of gender-affirming healthcare is to fix the “problem” of trans people being “born in the wrong body” (Johnson, 2015, p. 807). Contrary to queer-theoretical understandings of gender (Butler, 1990), which do not see gender as necessarily connected to physical bodies, a medicalized perspective considers aspects of bodies (e.g. breasts, genitals, and facial hair) as inherently gendered. This does not allow for trans people to be content with any part(s) of their body that do not “match” their gender identity and invalidates the gender of trans people who are content with any “gendered” aspects of their body.

Participants’ reports of re-telling the trans narrative highlights a potential difficulty in making progress toward trans-affirmative healthcare. If trans people continue to present themselves

according to a narrative at the advice of others who have accessed care, there will be little opportunity for trans people to present their gender authentically and receive the care they need from trans-affirmative healthcare professionals – information they can, in turn, feed back to their communities. Another potential consequence of presenting this narrative is that the narrative is *reified* for health professionals; if health professionals consistently hear similar stories from their clients, this might increase the likelihood they will expect the same story from future clients.

The experiences of participants in our study were consistent with the gender-affirming healthcare experiences of trans people reported in the extant literature. International research reports that trans people have been asked repetitive questions about gender during readiness assessments and felt a pressure to present gender in a way that conforms to the dominant trans narrative (Ellis et al., 2015; Frohard-Dourlent et al., 2020; McNeil et al., 2012). Very little previous research has investigated the experiences of trans people who have accessed gender-affirming healthcare in New Zealand, however our findings are also supported by past New Zealand-based studies in which participants reported a need to “fit a textbook description” (Pitts et al., 2009, p. 171) of trans identity to access care, or were reticent to discuss their mental health difficulties for fear they would be denied care (Ker et al., 2020).

Implications and future directions

Our analysis indicates that participants’ experiences of accessing gender-affirming healthcare deviated significantly from what would be expected according to WPATH best practice guidelines (Coleman et al., 2012). This may be (at least in part) attributable to the fact that when these interviews took place, there were no national guidelines for gender-affirming healthcare provision in New Zealand. The Ministry of Health provided online information for health professionals, however this was consistent with the WPATH v6 Standards rather than the updated v7 Standards (Ministry of Health, 2018b), meaning it did not reflect international best practice.^{4,5} It may be that this outdated information provided

by the Ministry of Health can account for the experiences of participants that often seemed to be in line with a pathologizing model of care, rather than the model of care described in the WPATH v7 standards.

It is possible that, with questions about childhood experiences of gender, professionals were attempting to confirm that clients' gender dysphoria was "persistent" (one of the criteria for accessing hormone therapy put forward in the WPATH standards; Coleman et al., 2012, p. 34). In the WPATH standards v7, however, the only guidance as to what constitutes "persistent" gender dysphoria is a reference to the (then upcoming) DSM-V criteria for gender dysphoria, which states that "six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis." (p. 71). As such, it is unlikely that health professionals would be required to establish the existence of gender dysphoria in early childhood in order to recommend access to care for adolescents or adults. Without speaking to mental health professionals involved in the provision of gender-affirming care it is impossible to know what model (if any) they were following, where they accessed information about healthcare provision, and the purpose of their assessment questions. Future research should explore health practitioners' perspectives about their role in providing gender-affirming healthcare in New Zealand.

Our analysis highlights the importance of taking a trans-affirmative approach to gender-affirming healthcare provision and ensuring that all health professionals in New Zealand share a common understanding of the purpose of readiness assessments for gender-affirming care, as well as what these assessments involve. There has been some progress in this regard since these interviews were conducted, with the publication of Oliphant et al. (2018) guidelines for gender affirming healthcare for gender diverse and trans children, young people and adults in Aotearoa. The guidelines are not intended to replace WPATH guidelines, but to "present additional guidance for the provision of gender affirming healthcare in Aotearoa, New Zealand" (p. 6). The Aotearoa New Zealand guidelines present the WPATH criteria for accessing care,

which include experiencing gender dysphoria (Coleman et al., 2012), and also refer to the informed consent model, which does not require experiencing gender dysphoria (Cavanaugh et al., 2016). Although the WPATH SOC state that they are intended as flexible clinical guidelines and are consistent with informed consent protocols (Coleman et al., 2012), we contend that referring to both the WPATH guidelines and informed consent model has potential to create confusion among clinicians about the degree to which they should focus on gender dysphoria during readiness assessments. As such, there is still a need for New Zealand-based guidelines that provide specific advice to health practitioners conducting assessments for gender-affirming care, to advise them of their role and what should be included in their assessment.

When updating New Zealand-based guidelines for gender-affirming healthcare provision, transgender health researchers and practitioners will likely grapple with the question of whether to reject gender dysphoria-based models entirely and adopt an informed approach to gender-affirming healthcare in New Zealand. According to some proponents of informed consent, the only way to de-pathologize gender-affirming healthcare and respect the self-determination of trans people is to view medical transition as a human right (Stop Trans Pathologization, 2012). The informed consent approach also addresses a key limitation of dysphoria-based models of care, as it ensures access to care for trans people who do not experience gender dysphoria but seek gender-affirming healthcare to increase comfort in their gender expression (Lev & Sennott, 2020). Many oppose this move to informed consent on the basis that moving entirely away from 'gender dysphoria' will threaten access to care, given that medical insurance companies generally refuse to fund services in the absence of such a diagnosis (Vance Jr et al., 2010). This concern is, however, somewhat less applicable in New Zealand, because our public health system has the power to approve funding for gender-affirming care in the absence of a diagnosis. Future research is needed to explore the potential consequences of adopting an informed consent model for trans people in Aotearoa.

Strengths and limitations

As the first analysis of trans young adults' experiences of readiness assessments for gender-affirming healthcare in New Zealand, this study makes a unique and much-needed contribution to the transgender health literature. We have provided valuable insight into the difficulties of accessing gender-affirming healthcare in the New Zealand context and the complexity of attempting to understand this process within an ever-changing system. A particular strength of our research is its community-based nature; by partnering with trans community organizations, we were able to ensure that our study was safe for participants and produced knowledge of benefit to trans communities in Aotearoa.

A limitation of the project was the absence of voices from minority groups within New Zealand's trans communities, including ethnic minorities, refugees and asylum seekers, people with disabilities and people living in isolated or rural areas. As such, our findings predominantly reflect the experiences and needs of able-bodied Māori and Pākehā, born in New Zealand, and living in New Zealand's larger cities. We must also note that our analysis captures a specific moment in time; when we conducted these interviews, New Zealand was in its ninth year of being governed by a center-right political party who had de-prioritized gender-affirming healthcare (Hine, 2016; Trevett, 2015). Later that year saw the election of a center-left party who campaigned on ensuring "access to affordable primary care based on the informed consent model" (Hanna, 2017, section 3). It is likely that this change in government, together with the 2019 establishment of the Professional Association for Transgender Health Aotearoa (PATHA, 2019), has changed Aotearoa's gender-affirming healthcare landscape.

Conclusion

We have provided an in-depth exploration of the gender-affirming healthcare experiences of 13 trans young adults living in New Zealand. Participants noted that they often felt a need to prove their gender during readiness assessments and to present their gender according to a dominant trans narrative. These experiences

closely reflect those reported in the wider literature, both in New Zealand and internationally. Our findings raise questions about the purpose of readiness assessments for gender-affirming healthcare and emphasizes that there is still much work to be done to provide affirmative trans healthcare in New Zealand.

Conflict of interest

The authors declare that they have no conflict of interest.

Statement of human rights

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study.

Notes

1. Here, we use Gender Minorities Aotearoa's (2017) definition of "trans" as an "umbrella term for people whose gender identity and/or gender expression differs from what is culturally typically associated with the gender/sex they were assigned at birth" (p. 3). We acknowledge that people under this umbrella may describe themselves using a wide variety of possible terms, and that some people who fit this definition may not consider themselves to be trans or identify under the trans umbrella. We use "New Zealand" and "Aotearoa" interchangeably throughout this paper — "Aotearoa" is the indigenous Māori name for New Zealand.
2. An indigenous Māori term that historically meant "intimate companion of the same sex" (Williams, 1871, p.147), but has been reclaimed to refer to all non-heterosexual, non-cis, and/or intersex Māori people (similar to rainbow; Kerekere, 2017).
3. A Pasifika umbrella term for rainbow identities: Mahu, Vakasalewa, Palopa, Fa'afafine, Akava'ine, Fakaleiti (leiti), Fakafifine (PrideNZ, 2011).
4. For example, the website noted that real life experience ("living and working full time for at least two years as a woman/man") was required to access hormones and surgery. Wi-Hongi and colleagues (2017) point out that "attempting to be read as the correct gender without appropriate medical support can have nega-

tive consequences” (p.156). These include exposure to physical and sexual violence, high social anxiety due to hypervigilance, and physical problems such as back pain and compressed ribs from binding one’s chest too tightly, or bladder infections as a result of avoiding public bathrooms. Due to these potential negative consequences, real life experience was removed from the WPATH Standards of Care in 2011.

5. These guidelines have since been updated, but readers interested in seeing the guidelines that were posted at the time of interviewing can visit <http://web.archive.org/> and search the website captures from February 2018.

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References

- Adams, N., Pearce, R., Veale, J., Radix, A., Castro, D., Sarkar, A., & Thom, K. C. (2017). Guidance and ethical considerations for undertaking transgender health research and institutional review boards adjudicating this research. *Transgender Health*, 2(1), 165–175. <https://doi.org/10.1089/trgh.2017.0012>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.
- Bizic, M. R., Jeftovic, M., Pusica, S., Stojanovic, B., Duisin, D., Vujovic, S., Rakic, V., & Djordjevic, M. L. (2018). Gender dysphoria: Bioethical aspects of medical treatment. *BioMed Research International*, 13, 1–6. <https://doi.org/10.1155/2018/9652305>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.
- Butler, J. (1990). *Gender trouble*. Routledge.
- Cavanaugh, T., Hopwood, R., & Lambert, C. (2016). Informed consent in the medical care of transgender and gender-nonconforming patients. *AMA Journal of Ethics*, 18(11), 1147–1155.
- Clark, B. A., Veale, J. F., Greyson, D., & Saewyc, E. (2018). Primary care access and foregone care: a survey of transgender adolescents and young adults. *Family Practice*, 35(3), 302–306. <https://doi.org/10.1093/fampra/cmz112>
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D. H., ... Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people (Version 7). *International Journal of Transgenderism*, 13(4), 165–232. <https://doi.org/10.1080/15532739.2011.700873>
- Davy, Z. (2015). The DSM-5 and the politics of diagnosing transpeople. *Archives of Sexual Behavior*, 44(5), 1165–1176. <https://doi.org/10.1007/s10508-015-0573-6>
- Deutsch, M. B. (2019). *Hormone therapy*. <https://transcare.ucsf.edu/hormone-therapy>
- Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One*, 6(2), e16885. <https://doi.org/10.1371/journal.pone.0016885>
- Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people’s experiences of mental health and gender identity services: A UK study. *Journal of Gay & Lesbian Mental Health*, 19(1), 4–20. <https://doi.org/10.1080/19359705.2014.960990>
- Fraser, G., Shields, J. K., Brady, A., & Wilson, M. (2018). *The postcode lottery: Gender-affirming healthcare provision across New Zealand’s District Health Boards* [Unpublished manuscript]. Victoria University of Wellington. <https://osf.io/f2qkr/>
- Fraser, G. (2020). *Rainbow experiences of accessing mental health support in Aotearoa New Zealand: A community-based mixed methods study* [PhD thesis]. Victoria University of Wellington. <https://researcharchive.vuw.ac.nz/xmlui/handle/10063/9042>
- Frohard-Dourlent, H., MacAulay, M., & Shannon, M. (2020). Experiences of surgery readiness assessments in British Columbia. *International Journal of Transgender Health*, 21(2), 147–162. <https://doi.org/10.1080/26895269.2020.1742842>
- Gender Minorities Aotearoa. (2017). *Glossary of gender related terms and how to use them*. <https://genderminoritiesaotearoa.files.wordpress.com/2016/06/gender-minorities-aotearoa-glossary-gender-minority-words-and-how-to-use-them.pdf>
- Hanna, M. (2017). *NZ political parties’ transgender health plans*. <https://honestuniverse.com/2017/08/30/nz-political-parties-transgender-health-plans/#labour>
- Hine, W. (2016, September 21). Doctor blasts ‘outrageous 40-year waiting list’ for NZ’s transgender patients. *One News*. <https://www.tvnz.co.nz/one-news/new-zealand/>

doctor-blasts-outrageous-40-year-waiting-list-nzs-transgender-patients

- Human Rights Commission. (2008). *To be who I am: Report of the inquiry into discrimination experienced by transgender people*. https://www.hrc.co.nz/files/5714/2378/766/1/15-Jan-2008_14-56-48_HRC_Transgender_FINAL.pdf
- Johnson, A. H. (2015). Normative accountability: How the medical model influences transgender identities and experiences. *Sociology Compass*, 9(9), 803–813. <https://doi.org/10.1111/soc4.12297>
- Ker, A., Fraser, G., Lyons, A., Stephenson, C., & Fleming, T. (2020). Providing gender-affirming hormone therapy through primary care: service users' and health professionals' experiences of a pilot clinic. *Journal of Primary Health Care*, 12(1), 72–78. <https://doi.org/10.1071/HCI19040>
- Kerekere, E. (2017). *Part of The Whānau: The Emergence of Takatāpui Identity - He Whāriki Takatāpui* [Doctoral thesis]. Victoria University of Wellington. https://researcharchive.vuw.ac.nz/xmlui/bitstream/handle/10063/6369/thesis_access.pdf?sequence=1
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Routledge.
- Lev, A. I., & Sennott, S. L. (2020). Clinical work with LGBTQ parents and prospective parents. In A. E. Goldberg & K. R. Allen (Eds.), *LGBTQ-parent families* (pp. 383–403). Springer.
- Lewis, E., Vincent, B., Brett, A., Gibson, S., & Walsh, R. J. (2017). I am your trans patient. *BMJ*, 357, 1–3.
- Lykens, J. E., LeBlanc, A. J., & Bockting, W. O. (2018). Healthcare experiences among young adults who identify as genderqueer or nonbinary. *LGBT Health*, 5(3), 191–196. <https://doi.org/10.1089/lgbt.2017.0215>
- McDonald, E., & Byrne, J. (2015). The legal status of transsexual and transgender persons in Aotearoa New Zealand. In J. M. Scherpe (Ed.), *The legal status of transsexual and transgender persons* (pp. 527–568). Intersentia.
- McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans Mental Health Study 2012*. Scottish Transgender Alliance.
- Meezan, W., & Martin, J. I. (2003). Exploring current themes in research on gay, lesbian, bisexual and transgender populations. *Journal of Gay & Lesbian Social Services*, 15(1–2), 1–14. https://doi.org/10.1300/J041v15n01_01
- Ministry of Health. (2018a). *Briefing on gender reassignment surgery: Health report number 20180307*. Ministry of Health.
- Ministry of Health. (2018b). *Gender reassignment surgery*. <http://www.health.govt.nz/our-work/preventative-health-wellness/delivering-health-services-transgender-people/gender-reassignment-surgery>
- Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, 72(2), 214–231. <https://doi.org/10.1111/j.1365-2265.2009.03625.x>
- Oliphant, J., Veale, J., Macdonald, J., Carroll, R., Johnson, R., Harte, M., Stephenson, C., & Bullock, J. (2018). *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa*. Transgender Health Research Lab, University of Waikato.
- Pitts, M., Couch, M., Croy, S., Mitchell, A., & Mulcare, H. (2009). Health service use and experiences of transgender people: Australian and New Zealand perspectives. *Gay and Lesbian Issues and Psychology Review*, 5(3), 167–176.
- PrideNZ. (2011). *Phylesha Brown-Acton delivers a keynote presentation*. http://www.pridenz.co/apog_phylesha_brown_acton_%0Akeynote.html
- Professional Association for Transgender Health Aotearoa. (2019). *New group advocates for the health of transgender people*. <https://patha.nz/News/8098805>
- Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism*, 6(1), 97–103
- Riggs, D. W., Pearce, R., Pfeffer, C. A., Hines, S., White, F., & Ruspini, E. (2019). Transnormativity in the psy disciplines: Constructing pathology in the diagnostic and statistical manual of mental disorders and standards of care. *American Psychologist*, 74(8), 912–924. <https://doi.org/10.1037/amp0000545>
- Rowe, W. (2014). Auditioning for care: Transsexual men in Ontario accessing health care. In D. Irving & R. Raj (Eds.), *Trans activism in Canada: A reader* (pp. 209–224). Canadian Scholars' Press.
- Russell, G. M., & Bohan, J. S. (2005). The gay generation gap: Communicating across the LGBT generational divide. *Angles: The Policy Journal of the Institute for Gay and Lesbian Strategic Studies*, 8(1), 1–8.
- Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanistic Psychology*, 58(1), 72–92. <https://doi.org/10.1177/0022167817745217>
- Serano, J. (2016). *No desistance, detransition and disinformation: A guide for understanding transgender children debates*. <https://medium.com/@juliaserano/detransition-desistance-and-disinformation-a-guide-for-understanding-transgender-children-993b7342946e>
- Sperber, J., Landers, S., & Lawrence, S. (2008). The health and social services needs of transgender people in Philadelphia. *International Journal of Transgenderism*, 8(2–3), 31–47.
- Stop Trans Pathologization. (2012). *Manifesto: International network for trans depathologization*. <https://www.stp2012.info/old/en/manifesto>
- Taylor, E. T. (2013). Transmen's health care experiences: Ethical social work practice beyond the binary. *Journal of Gay & Lesbian Social Services*, 25(1), 102–120. <https://doi.org/10.1080/10538720.2013.750575>
- Temple Newhook, J., Pyne, J., Winters, K., Feder, S., Holmes, C., Tosh, J., Sinnott, M.-L., Jamieson, A., & Pickett, S. (2018). A critical commentary on follow-up studies and

- “desistance” theories about transgender and gender-nonconforming children. *International Journal of Transgenderism*, 19(2), 212–224. <https://doi.org/10.1080/15532739.2018.1456390>
- Trevett, C. (2015, May 20). Sex-change funding not a priority. *New Zealand Herald*. https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11451289
- Vance, S. R., Jr., Cohen-Kettenis, P. T., Drescher, J., Meyer-Bahlburg, H. F., Pfäfflin, F., & Zucker, K. J. (2010). Opinions about the DSM gender identity disorder diagnosis: Results from an international survey administered to organizations concerned with the welfare of transgender people. *International Journal of Transgenderism*, 12(1), 1–14. <https://doi.org/10.1080/15532731003749087>
- Veale, J., Byrne, J., Tan, K., Guy, S., Yee, A., Nopera, T., & Bentham, R. (2019). *Counting ourselves: The health and well-being of trans and non-binary people in Aotearoa New Zealand*. Transgender Health Research Lab, University of Waikato.
- Vipond, E. (2015). Resisting transnormativity: Challenging the medicalization and regulation of trans bodies. *Theory in Action*, 8(2), 21–44. <https://doi.org/10.3798/tia.1937-0237.15008>
- White Hughto, J. M., & Reisner, S. L. (2016). A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgender Health*, 1(1), 21–31. <https://doi.org/10.1089/trgh.2015.0008>
- Wi-Hongi, A., Greig, A., & Hazenburger, E. (2017). Towards a model of informed consent: Trans healthcare in Aotearoa New Zealand. In E. Hazenberg & M. Meyerhoff (Eds.), *Representing trans: Linguistic, legal and everyday perspectives* (pp. 153–170). Victoria University Press.